Telephone interview with CAPT Joseph M. Ricciardi, MC, USN (Ret.), participant in the Repatriated Prisoner of War program. Conducted by Jan K. Herman, Historian of the Navy Medical Department, 6 February 2004.

Where are you from?

I'm originally from northern New Jersey about 8 miles from New York City in Bergen County, a stone's throw from the George Washington Bridge. I went to high school in northern Jersey. I went to college in Georgetown in Washington. I got a master's degree on Long Island, and then I graduated from Georgetown Medical School in 1970. I got into an internship at the country hospital in Nassau County on Long Island, then applied for a Berry Plan deferment. I'm sure you're familiar with Dr. Berry from World War II.

Evidently, I was one of the last two or three "Berry Planners" still on active duty when I got out, if not the very last one. I thought it was a very worthwhile plan because I had young kids and was able to finish my residency and then come on active duty as an orthopedic surgeon.

I started out with a 3-year tour at Cherry Point in North Carolina with the Marines and I enjoyed that so much that I asked to be considered for another tour and they told me I could go anywhere I want. So I said, Newport, and they said I couldn't go there. My brother in law had been in the aviation pipeline in Pensacola. And he said, "You've got to go to Pensacola. You'll love it."

I got to Pensacola in 1978 and within a month of getting there, I was asked by one of the clinic nurses to see a patient who didn't have an appointment. I asked her why I should do that. I wasn't on call but the on-call guy wouldn't see him, and the head of the department was too busy. She said, "These are our POW patients. We don't know when they're going to be coming in. A lot of them need orthopedic consultations." And I thought, nobody is too busy to see one of the POWs. So that's how I started seeing all the patients that CAPT Bob Mitchell was referring. I found it to be the best part of my career and a tremendous eye-opener.

I trained in a county hospital and saw every sort of vile damage that one human could do to another. But it took all of my New York-New Jersey smarts and toughness to sit down and not cry when these patients would matter-of-factly describe how they were broken and dislocated on ejection, how they were repeatedly tortured, had their arms pulled out of sockets to get information from them, and how they were routinely beaten and mistreated.

I was in Pensacola from '78 to '87 and I saw every POW every year who needed an orthopedic evaluation. And it was one of the most tremendous experiences I've ever had working with these men and trying to absorb some of the horror that they went through.

How did the consultations work?

Dr. Mitchell would send me a typical military consultation request typed out very nicely. "Please see this 42-year-old aviator, RPOW [returned prisoner of war] with a history of ejection injuries to the shoulders and other injuries to the arms and legs." So I would sit down with the patient and we'd do an interview. I'd try to make a list of all the things that hurt--all the things that were injured. And then we would examine every injured part and we'd always have x-rays. We took the x-rays on a yearly basis. Many of the POWs had had ejection injuries to their knees or their upper extremities, or both. They were routinely not treated or maltreated by their captors. A number of the men had dislocated shoulders.

One of the favorite tortures was to bring them in for a questioning session and keep redislocating their shoulder. A number of the men had had their hands tied behind their back and

then their elbows were tied together behind their back, if you can imagine that. Ropes were then passed around their wrists, thrown over a beam in the ceiling, and then they were pulled up with their hands behind their back until their shoulders would tear or dislocate or break.

So, they had a significant number of very traumatic injuries. What we learn with every war is that untreated orthopedic injuries lead to early arthritis. So these were people who had to deal with pain, who had to deal with injuries that weren't treated anywhere from 1 to 7 years. Many of them came back with a whole lot less than normal or even good function in their arms, legs, and spines.

I tracked the POWs that I saw along with a very well put together control group that CAPT Mitchell had made and I was able to show a comparison in my statistics with the POW group having a much higher rate of osteo-arthritis than the control group, and a much higher rate of nerve injuries because when you get your arms and wrists tied behind your back, or are manacled by your legs for months, your nerves will get pressure on them and the nerves will stop functioning. You can have foot drop or wrist drop. You can get carpel tunnel syndrome and ulnar nerve injuries.

Fortunately, I was in a position in about 1988 or '89 to testify at the VA Special Committee on POWs in Washington. As a result of the work that Dr. Mitchell did and some of the reports that I made, the VA has considered degenerative arthritis in a POW as presumptively coming from active duty and from the POW injury. They don't have to prove a service connection. The service connection is presumed. I think the same thing now holds true for the nerve injuries. I was just a person in the right place at the right time able to document these things.

You were the documenter. Did you actually do any remedial treatment for any of these men?

I did. A number of these folks had had surgery between 1973 when they were repatriated and 1978 when I first saw them. But I did a number of operations on these men, primarily for the nerve problems--taking the pressure off nerves, carpel tunnel releases, ulnar nerve transpositions, and more recently, two shoulder rotator cuff repairs. Some of them had already had their knees worked on. Some of them had a new duty station or a retired status where they had developed a good relationship with an orthopedic surgeon. So there was a tremendous amount of reconstruction surgery that was done on these men. And I did a little bit of it.

Was there a high degree of success in reversing a lot of these very serious injuries?

When you talk about bad arthritis in the knees, the only way to get a successful outcome is to do knee replacements. A lot of the folks were too young when they came back for knee replacements. But I follow their progress on the POW email net and the number of shoulder, hip, and shoulder replacements is out of all proportion to their age groups. The replacements are showing up now. I don't know if anybody is capturing that data. I suspect the Mitchell RPOW Medical Center is but I don't have those numbers.

So, these surgeries would be done in other naval hospitals or VA hospitals.

Of course, a number of the folks who don't live near military hospitals have medical insurance and they're getting them done at university hospitals or flagship tertiary care hospitals in different states. So they are being done all over, not just in military hospitals.

Were there any patients in particular where you saw a range of injuries you never could have imagined could be sustained by one individual?

Yes. It would be very hard not to give identities away, but we won't mention names. I saw one person who was getting ready to get out. I sat down with that individual for the better part of 2 hours and catalogued all the injuries. I picked up one he didn't even know about because when I x-rayed his hip the x-ray techs got far enough down at the thigh for me to see a healed thigh fracture. He had been beaten up very badly and then placed in leg irons on the concrete deck for months. And his femur fractured which he didn't know about because the rest of his body was so horribly beaten up. That healed and he never knew about it.

But he also made a documentary for the Navy about kinds of things he'd done and he was shown swimming in a pool at a naval facility. It was to show that he couldn't run anymore but he was still doing his physical fitness training. But he wasn't moving his left shoulder. I saw him in the morning and then I saw the film at lunch time, and then I saw him back in the afternoon and examined his left shoulder. He had had an undiagnosed fracture in that shoulder. That man had at least nine separate orthopedic diagnoses. And there were any number of people with six, seven, and eight diagnoses, specific parts of their bodies that were fractured, dislocated, damaged, or otherwise injured. It was just incredible!

Fortunately, you will probably never see that kind of abuse again in your practice.

No. I have come to a belief that it really helped those men to be part of a community. I think one person all by himself in isolation for 6 or 7 years would have a hard time keeping their sanity and not giving up if they were by themselves. But these men fed each other. They cleaned each other. They tolerated each other's dysentery. When a fellow would break under torture, they'd all point out to him that everybody breaks under torture. I think an understanding of the code of conduct was greatly improved. What the POWs had to do for themselves was come to an understanding that a man would hold out until he was afraid of losing his life, a limb, or his sanity. And after that, you just had to make the torture stop. They're all tough guys. They all had their limit but they all stuck together as a community, with about a half dozen traitorous exceptions. They were just an outstanding example of what good human conduct can be in adverse situations. And I'm proud to be in the same military with these sailors, soldiers, airmen, and Marines. I think it's just wonderful to know these people and know about them.

I have a story I just have to tell you. After I had been seeing Bob Mitchell's patients for about a year, he said, "I want you to come to lunch with me and two other guys in the program. He took me to lunch and I was sitting opposite him. To my right and to my left were two Medal of Honor winners. And there I am, a very junior lieutenant commander sitting between a vice admiral, a Navy captain, and an Air Force colonel. I didn't close my mouth once during the whole lunch. I just sat there with my head turning like I was watching a tennis match. When you sit down at a table with heroes, you learn not to talk.

I've already interviewed Jack Fellowes for this study and he has quite a story.

We had a lot of trouble with medical board separations for the POWs. You may have heard another version of this story but I'll give you the version I know. When the POWs came back from Vietnam, Melvin Laird was Secretary of Defense. Supposedly a memo went out over his signature that said, we want to keep as many as of these guys on active duty as possible no matter what their condition. So, many of them were waived for their impairments and allowed to go take NATOPS training for their different aircraft. And a great number of them were returned

to flight duty, even though they had impairments that would constitute disabilities. When it came time for them to get out, Melvin Laird was long gone, the memo had disappeared, and anybody O-5 and above who was a POW that had all of these horrible--two, three, four, five, six, seven, eight diagnoses--was being turned down by the physical evaluation board when it was time to get their disability rating.

If you're well enough to fly, then you can't be that injured.

Which is not true but . . . And a lot of that went back to a couple of four-stars who were on flight status one day and retired the next day on a hundred percent disability. That was in the mid to late '70s when that happened. And, of course, I started doing the POW medical boards. In fact, we had people who couldn't bring their hand up to their forehead to salute unless they kept their elbow at their side. We had one fellow whose thumb had been cut off. We had a number of people who had such bad leg fractures that when they stood up straight both of their feet pointed in the same direction instead of apart. They certainly had impairments that were essentially disabling but they were allowed to try to stay on active duty much as that young man from the first Gulf war who was an upper extremity amputee was allowed by Max Cleland to stay on active duty. But when it came time for them to retire, the deal was: This is when your disability will be taken into account.

We had a tremendous time with some really rigid, hard-nosed individuals who didn't think the POW experience was all that tough that it merited some consideration from them when these folks were retiring. And finally, Jack Fellowes got assigned to the PEB and I worked as closely as I could with him and, in fact, I came up from Pensacola to DC and testified at the PEB on a number of cases. And that is when the climate started to change so that folks who had all of these horrible injuries--which we were able to prove were getting worse every year in terms of loss of motion, increased changes on x-rays, functional impairments getting worse--that these folks were finally rated the way they should.

The mistake that was made was that every one of these men should have had a medical board when they came back documenting their disabilities, and finding them unfit, and then had those disabilities waived until they retired. That would have dotted all the I's and crossed all the T's but that's a technical kind of thing that most folks outside the Medical Department and the POW community wouldn't want to spend a lot of time on.

So these injuries were documented after rather than before.

When they came back every one of them had their conditions documented, but medical boards were not done. Some of them had to go before special boards of flight surgeons before they could get back into flying. You have to remember that a lot of these folks wanted to stay on active duty and they did everything they could to fight to stay on active duty. But then they started getting worse. I took x-rays year after year on these guys and the joints wore out faster. The joints wore out faster in the POWs than they did in the control groups. There were hardly any nerve injuries in the control group. For a long period of time the POW group was so malnourished that their heart disease rate was much lower than the control group. And it wasn't until they'd been back about 10 years and had been eating well and getting into a more indulgent lifestyle that their heart disease rate started to catch up to the rest of the population.

I was going to ask you about the state of their nourishment, which was rather poor. When I spoke to CAPT Fellowes about it, he said there certainly weren't any fats. It was

very basic food, enough to sustain life but it didn't have all the ill effects a high fat diet would have.

But when you don't have fat, there are four vitamins you don't get--A, D, E, and K. So most of these folks have some visual acuity problems worse than the control group. They certainly had poor nerve nutrition which is why I think the rope tortures that they had left them with so many permanent nerve injuries because there was no way for the nerves to completely recover physiologically. So the starvation diet had some positive aspects but it also had negative aspects in terms of their vision and their nerve function.

Long range, then, their cardiovascular conditions ended up catching up with the control group?

I understand that that's the case. Bob Mitchell could certainly verify that but I think that's what happened.

I've studied a little about the World War II POWs who were held by the Japanese and many of them had vision problems because of vitamin deprivation. Several lost their peripheral vision. And their cardiovascular condition in later years was generally not favorable. There were many circulatory problems. Of course, I think their diet was even worse than what the Vietnam POWs had. They certainly had all the deficiency diseases you can imagine--pellagra, scurvy, beriberi.

There are differences, of course. The Japanese tended to kill the people who were doing poorly so you had to have an iron constitution to survive as a prisoner. For years, the VA thoroughly resented the fact that the NAM-POWs (The Association of the Repatriate Viet Nam Prisoners of War) were trying to get somebody to understand their niche, somebody to understand their problems. I heard a comment pass when I was at the VA in the late '80s. "Well, you know, there are something like 49, or 59, or 69,000 World War II POWs that we're still taking care of." And, of course, the question was, how many of them were prisoners for 7 years? How many of them were tortured? And those questions had no good answers. How many of them were ejected from high-performance aircraft and had their joints torn apart?

I'm impressed that the POW group has been able to obtain the medical care and the recognition that they need as a group and I credit Bob Mitchell for all of that. Bob Mitchell has to be standing right in front of the picture as far as I'm concerned.

Well, that's certainly a universal opinion. Everyone I've talked to on this subject agrees with your assessment. I hear the word prince a lot. And after talking with him at length, I agree that he is indeed a prince.

When did you leave the Navy?

I left the Navy in January of '98. I had made arrangements before that to go into practice here in Arkansas with a former CO of mine, who was one of the very first female orthopedists in the Navy--Alice Martinson. Alice had a couple of commands before she got out, and she got out 8 years before I did. We've stayed friendly since the early '80s. She said, "Come on up here and we'll go partners." So I did and its been a good 6 years.

So you've been in practice in Berryville.

It's a small town. We're out in the woods. The economy is cattle and chicken houses. The biggest store for 30 miles is a Wall Mart Super Center.

This is not Bergen County.

And it's not Washington, DC. But it's great to wake up in the morning and see deer, coyote, foxes, and rabbits running in your backyard. I'm enjoying it.